Annual Report of the Health Insurance Benefits Advisory Council

July 1, 1972—June 30, 1973

BHI Pub. No. 006–73 (3-74)

Annual Report of the Health Insurance Benefits Advisory Council

July 1, 1972—June 30, 1973

U.S. Department of Health, Education, and Welfare
Social Security Administration
Bureau of Health Insurance
September 1973
BHI Pub. No. 006-73 (3-74)

Table of Contents

November 2, 1973

Honorable Casper W. Weinberger
Secretary of Health, Education,
and Welfare
330 Independence Avenue, SW.
Washington, D.C. 20201

Dear Mr. Secretary:

This annual report for fiscal year 1973 is submitted in accordance with the provisions of the Health Insurance Benefits Advisory Council Charter, approved January 4, 1973 (Appendix No. 1). The Council's members and staff hope that it will be helpful to you in your own evaluation of the Medicare and Medicaid programs during FY 1973 and in our mutual quest for continued improvement in the performance of the two programs.

Sincerely yours,

James R. Cowan, M.D.
Chairman
Health Insurance Benefits
Advisory Council

Membership of the Council

Carl E. Anderson, M.D., Clinical Professor of Orthopedic Surgery at the University of California Medical School and member of the staff of the Santa Rosa Memorial Hospital, Santa Rosa, California

Melnea A. Cass (Mrs.), Chairman, Massachusetts Advisory Committee for Elderly Affairs

G. Robert Cotton, Ph.D., President and Chief Administrative Officer of the Cedar Knoll Rest Home, Inc., Grass Lake, Michigan

James R. Cowan, M.D., Commissioner of Health of the State of New Jersey

Leonard W. Cronkhite, Jr., M.D., Executive Vice President of the Children's Hospital Medical Center, Boston, Massachusetts, and Lecturer in Preventive Medicine at the Harvard University Medical School

**Nelson H. Cruikshank,* former Director, Department of Social Security, AFL-CIO; President, National Council of Senior Citizens, Inc.

James Rodney Feild, M.D., Private practice of neurosurgery, Mid-South Neurological Clinic, Memphis, Tennessee

**Msgr. James H. Fitzpatrick,* Director of Government Relations, Hospital Association of New York State

Oscar E. Gutierrez, D.O., Director of the Davila Medical Center, San Antonio, Texas

Laura Larson, R.N. (Mrs.), Coordinator of Nursing and Allied Health in the Mountain States Regional Medical Program of the Western Interstate Commission on Higher Education

Edwin H. May, Jr., former U.S. Representative, 85th Congress; President, May, Potter, Murphy, and Carter, Inc., Hartford, Connecticut

Sam A. McConnell, Jr., Member, Arizona State Legislature; owner, McConnell Pharmacy

William S. McNary, Retired President, Michigan Blue Cross.

**Sherwin L. Memel, J.D.,* Attorney at Law; Consultant in Health Law and Economics, Los Angeles, California

Stanley A. Miller, Former Secretary, Department of Public Welfare, State of Pennsylvania

**Jay S. Reibel, M.D.,* Resident in Psychiatry, Mt. Sinai Hospital, New York City

Helene K. Sargeant (Mrs.), Former member of the Medical Assistance Advisory Council (Medicaid); civic worker, Wellesley Hills, Massachusetts

Ernest W. Saward, M.D., Associate Dean of the University of Rochester School of Medicine and Dentistry; Chairman of Board, Group Health Association of America.

Sister Virginia Schwager, Director, Division of Health Affairs, United States Catholic Conference, Washington, D.C.

Bert Seidman, Director, Department of Social Security, AFL-CIO

Anne R. Somers (Mrs.), Associate Professor, Department of Community Medicine, College of Medicine and Dentistry of New Jersey, Rutgers University, and Research Associate, Industrial Relations Section, Princeton University

**J. Minott Stickney, M.D.,* Professor of Clinical Medicine at the Mayo Graduate School of Medicine, University of Minnesota; Program Coordinator of the Regional Medical Programs for the Northlands Region

Harlan Thomas, M.D., General practice of medicine, Tulsa, Oklahoma

*Council terms now expired

I. Introduction

A. Redefinition of the Council's Role

The Social Security Amendments of 1972 (enacted October 30, 1972, as Public Law 92–603) substantially redefined the Council's responsibilities and role. In the first place, these responsibilities were enlarged as a result of the termination of the Medical Assistance Advisory Council which had responsibilities similar to those of HIBAC with respect to the Medicaid program. The MAAC responsibilities were transferred to HIBAC. This consolidation of the advisory functions under HIBAC is consistent with Congress' earlier action in transferring to it the duties originally contemplated in P.L. 89–97 for the National Medical Review Committee.

Second, it is clear from the Report of the Senate Finance Committee that Congress wishes the Council to concentrate on "matters of general policy in the Medicare and Medicaid programs" rather than on the formulation of regulations and the "often routine modifications and refinements" in such regulations. The specific functions, formerly spelled out in Section 1867, Title XVIII of the Social Security Act, have been deleted. Among these was the requirement that HIBAC submit an annual report to the Congress.

Section 1867 now defines HIBAC's role as ". . . to provide advice and recommendations for the consideration of the Secretary on matters of general policy with respect to this title [XVIII, Medicare] and title XIX [Medicaid]." The definition of HIBAC's redefined structure, functions, meeting arrangements, and costs were further spelled out in a new Charter, approved by Secretary Elliot L. Richardson, January 4, 1973 (Appendix 1).

As a result of these changes and other developments in the Department of Health, Education, and Welfare, including the absence of a Commissioner of Social Security for a substantial portion of the year, there has been serious concern on the part of Council members as to the exact role envisaged for the Council by the Secretary. On the one hand, we welcome the explicit responsibility to advise on "matters of general policy" affecting the future of Medicare and Medicaid and the inevitable implication for a future national health insurance program. On the other hand, we want to make sure that our deliberations take place in a context that will be productive both from the Department's point of view and that of individual Council members.

B. Schedule of Meetings

Primarily as a result of these changes, the Council met less often than in previous years. The six meetings held during FY 1973 were as follows:

July 7–8, 1972—Washington, D.C.
September 15–16, 1972—Baltimore, Md.
October 27–28, 1972—Washington, D.C.
December 1, 1972—Baltimore, Md.
January 19, 1973—Baltimore Md.
May 11–12, 1973—Baltimore, Md.

The July 1972 meeting was the first one open to the public pursuant to Executive Order 11671. Also, in accordance with P.L. 92–463, the Federal Advisory Committee Act (which superseded E.O. 11671), staff papers prepared for the Council, as well as Council discussions, are made available to the public, and the public is invited to make comments at the conclusions of each meeting. Interested persons attending the Council meetings included representatives of the American Medical Association, the American Hospital Association, and other organizations representing health-oriented groups, as well as reporters for various medical publications. Such representatives, in general, made very few comments at the time designated for remarks by the public.

C. Major Concerns and Activities

Council deliberations during the year dealt with a wide range of subjects. Part II of this report summarizes the major issues upon which formal action was taken; Part III, those that resulted in no formal action but reflect the members' deep concern.

II. Principal Issues Upon Which Formal Action Was Taken

A. Physician Reimbursement

Pursuant to the expressed intent of H.R. 1 (enacted as P.L. 92–603), the Council conducted an in-depth study of the methods of reimbursement for physicians' services under Medicare. The purpose of the study was to determine the effects of Medicare methods of reimbursement on (1) physicians' fees generally, (2) the extent of assignments of Medicare claims accepted by physicians, and (3) the share of physician-fee costs which the beneficiary must assume. This information would form a basis for recommending to Congress alternatives to the present methods of reimbursement as well as a preferred method.

The report of the results of the study was assembled with the advice and help of an ad hoc committee established by the Council. When the report was completed, the Committee was under the Chairmanship of Edwin H. May and included as members Carl E. Anderson, M.D.; William S. McNary; Ernest W. Saward, M.D.; and Harland Thomas, M.D. Former members of HIBAC who contributed to the development of the report were: Nelson H. Cruikshank; Merrill O. Hines, M.D.; Jay S. Reibel, M.D.; Charles Schultze; Herman M. Somers; and J. Minott Stickney, M.D.

Besides reviewing extensive information available from the Social Security Administration records, the Committee requested the Administration to contract for the services of two consulting firms with staff distinguished in the field of medical economics. The Research Triangle Institute (RTI), of North Carolina, and Robert R. Nathan Associates of Washington, D.C. were selected as the contractors to conduct studies of various aspects of Medicare reimbursement.

RTI conducted a sample survey of physicians to examine the factors physicians take into consideration in deciding whether to accept assignments and the billing arrangements physicians may make for the deductible and coinsurance features of reimbursement. Among its findings, RTI reported that the most important factor considered by physicians in accepting assignments is the patient's ability to pay the bill: if he can do so, the physician is less likely to accept an assignment. The survey also suggested that when Medicare's allowed fee is less than the physician's total charge, the rate of assignment is reduced. In general, the survey showed that physicians have little difficulty in collecting the annual $50 deductible amount from Medicare patients, but some difficulty was reported in collecting the 20 percent coinsurance charge.

Robert R. Nathan Associates analyzed the effect of the advent of Medicare and Medicaid on physicians' fees and the utilization of Medicare coverage by beneficiaries. The Nathan staff concluded that the rate of increase in physicians' fees accelerated as a result of the passage and implementation of the Medicare and Medicaid programs. Their study also noted that where a fee schedule had been used as a method of reimbursement prior to the establishment of the physicians' customary charge, it appeared to act as a brake on the rate of increase in fees.

In carrying out its work, the Committee met periodically with the consultants and SSA staff for the purpose of reviewing and evaluating proposed study designs, statistical data gathered, and drafts of findings and recommendations. The Committee reported regularly to the full Council on the progress of the study and obtained frequent valuable input from Council members.

The conclusions of the study were as follows:

1. The Medicare program has achieved its primary objective of providing a basic floor of health insurance protection for the aged. With respect to the costs of physicians' services for the average beneficiary (including the deductible, coinsurance, and premium payments as well as other out-of-pocket expenses), the proportion of these costs being paid by the program increased substantially in the early days. However, this proportion is too small to permit complacency and has been falling rather than rising since 1970.

   In the past 3 years, measures have been adopted which resulted in the establishment by carriers of more precise customary charge profiles and prevailing charge screens. These improvements have helped to slow the rate of increase in charges under Medicare.

2. Alternatives to the present methods of reimbursement under the Medicare program should include the following principles:

   a. Any changes in the reimbursement for physicians' services under the Medicare program should not encourage a reduction in access to such services by the beneficiaries; i.e., physician participation should not be discouraged.

   b. Any changes in the present method of reimbursement under the Medicare program should take into account the various forms of payment for health care in the private sector.

c. No method of physician reimbursement should categorize the beneficiaries in a manner of payment significantly different from the general public.

d. Beneficiaries should not be liable for physicians' fees beyond the deductible and coinsurance amounts.

e. Attempts to change the reimbursement method should carry the reasonable expectation that physicians' fees under Medicare will be equivalent to the levels in other existing reimbursement programs.

These were the recommendations:

1. Experimentation with the concept of "participating physicians" in the Medicare program should be undertaken by the Administration in selected areas. The objective of such experiments would be to evaluate the willingness of physicians to participate in the program and at the same time eliminate the need for beneficiaries to pay out-of-pocket more than the deductible and coinsurance.

2. Experiments with any reasonable type and form of payment for physicians' services, such as fee schedule, capitation, and relative value scale, should be encouraged under Medicare for physicians desiring to participate in such a project as long as the costs are likely to be the same or less than those derived from the reasonable charge formula under the existing law. In the design of such experiments, it is necessary to give full consideration to regional differences, inherent inequities, inflation, and other variables.

One member, while signing the general report, attached a separate statement calling for an aggressive system-wide development of a fee schedule program with strong incentives for voluntary participation of physicians."

B. Conditions of Participation for Home Health Agencies

The Council reviewed and endorsed the final conditions of participation for home health agencies. These reorganized conditions of participation were restated for conciseness and revised to include provision for (1) annual certifications and recertifications of home health agencies to conform to State licensure cycles for health facilities and services, and (2) annual program evaluations designed to encourage agencies to evaluate their performance on a continuing basis in meeting program requirements and community needs. The proposed final regulations also authorized the use of physical therapy assistant

services under appropriate supervision. In addition, the revised regulations expanded participation conditions by providing:

1. That a home health agency have a governing body legally responsible for its operation;
2. That the administrator, if other than a physician or registered nurse, meet certain qualifications and assume certain responsibilities;
3. That branch offices shall automatically meet the conditions of participation approved for the parent agency;
4. That owners of agencies be identified; and
5. That the content of a contract be specified in detail.

C. Physician Certification

Physician certification and recertification of medical necessity for inpatient hospital care was discussed in detail. The American Council of Medical Staffs presented their views opposing the requirement that physicians certify medical necessity more frequently than the maximum periods specified in the law. It is the contention of ACMS that certification on the 12th and 18th days has had no effect in reducing the length of hospital stays but has imposed a considerable burden on physicians. ACMS believes that the law should be amended to delete the physician certification provision.

The Council voted against changing the timing of physician certifications and recertifications on the ground that such requirements during a period of great cost consciousness represent an important means by which physicians can help assure the public that hospitals are properly utilized. Such certifications also constitute evidence of medical need that is useful in claims administration, and usually involve only a minimal amount of physician time, as they are an automatic byproduct of his examination of a patient and review of the patient's records. Since the average Medicare short-term hospital stay is now just over 12 days, it would seem appropriate to retain the 12th day for the initial certification date.

D. Chiropractors' Services

The Council expressed concern about coverage of chiropractors' services under the 1972 amendments, contending that liberal interpretations of such coverage could result in very costly services without commensurate benefit to beneficiaries. However, the Council also observed that pressure from consumers

of chiropractic coverage could be an indication of the lack of availability of primary care services. In November, the Council informed the Secretary that it favored the formulation of strict standards governing the performance of covered chiropractic services under P.L. 92–603 and wished to participate in the development of policy recommendations for such standards. (Appendix 2)

E. Disclosure of Reports and Other Informaiton

The Council considered the implications of proposed regulations to permit disclosure of various Medicare survey reports, including State health agency reviews of hospitals, extended care facilities, home health agencies, and independent laboratories. Under the revised regulations, identities of providers of services, physicians, and other persons who have been found guilty of submitting false claims in connection with the furnishing of services to Medicare beneficiaries would become publicly available. Likewise, the identity of those found to have engaged in a pattern of furnishing services or supplies in excess of the medical needs of patients would be disclosed.

The Council expressed concern that procedural safeguards be sufficient to protect against premature disclosure of the names of such physicians or other suppliers, but defeated a motion recommending that concurrence of the State medical society must be obtained before disclosing the name of a physician found by a carrier to have engaged in a pattern of furnishing services in excess of medical need. The majority felt that, in the interest of public accountability, the Secretary should not delegate such authority to a medical society. It was the Council's opinion that veto power by a medical society under these circumstances could be contrary to public interest.

F. Reimbursement of Stock Maintenance Costs

The Council heard arguments by representatives of the Federation of American Hospitals (FAH) favoring Medicare reimbursement for the costs of obtaining and maintaining private capital through the sale of corporate capital stock as a legitimate expense in operating proprietary hospitals. SSA considers these nonreimbursable expenses because they are not directly related to patient care activities. There are, moreover, special provisions for reimbursing proprietary providers for the equity capital they invest. Such provisions allow for a return on equity capital related to the going price for renting money, rather than to the audited out-of-pocket cost the proprietor incurs in making or maintaining his investment in the provider.

In short, the position of SSA is that stock maintenance costs are subsumed under the return on equity capital.

It was the view of the Council majority that (1) the Internal Revenue Service definition of cost, which embraces stock maintenance costs, should be used by all parties, and (2) costs which are related to the viability of a medical institution are related to patient care. Stock maintenance costs are allowed by the Department of Defense as defense contract costs. A view held by a minority of Council members was that stock maintenance costs are already reimbursed under the return on equity capital and that the FAH position would result in paying twice for the same services.

The Council voted against a motion to support the staff position and approved a motion recommending that, in determining a provider's reimbursable costs, all costs related to the viability of the organization be deemed related to patient care and, therefore, includable in allowable cost. In this context SSA feels that a definition of "viability" is essential; otherwise, the Government might find itself protecting from bankruptcy all organizations having financial difficulties.

III. Principal Issues Upon Which No Formal Action was Taken

A. Medicaid Orientation

At its January 1973 meeting, the reorganized Council held a special Medicaid orientation session. From this time on, the agenda reflected the Council's dual interests and concerns.

The Council specifically requested additional information from the Medical Services Administration on the Medicaid early childhood screening program as a basis for consideration of strengths, weaknesses, and possible refinements.

B. Mental Health

The HIBAC Committee on Mental Health, which was established in March 1972 to review the coverage of benefits for the mentally ill under Medicare, continued its search for data on the cost of possible improvements in coverage of outpatient and inpatient treatment for mental illness, including costs incident to possible removal of the $250 limitation on outpatient psychiatric services and the addition of provisions to cover partial hospitalization for mental conditions. The Committee expects to be in a position to make a valid judgment with respect to recommending expansion of the mental health coverage under Medicare upon receipt of pertinent cost data requested from the Office of the Actuary.

C. Carrier and Intermediary Performance

The Council received reports on procedures used by SSA to monitor and evaluate the performance of intermediaries and carriers. At the outset of the Medicare program, reporting procedures were devised to enable contractors to provide essential operating data, primarily related to workload and processing time. In addition, administrative cost information was maintained with respect to all program contractors. Over time and with added program experience, SSA developed the broad range of informational tools presently used to monitor and evaluate the effectiveness of contractors' operations. These encompass a variety of statistical reports, an extensive program of onsite reviews at carrier and intermediary locations by SSA Central Office and field components, and a continuing series of EDP systems tests directed toward appraising the Part B claims review process.

Under the decentralized approach to program administration, the immediate responsibility for overseeing and appraising contractor performance rests with the health insurance regional

offices which are continually involved in onsite reviews of carriers' and intermediaries' processes. The resident health insurance representative program is an important part of the regional surveillance capability. Under this program, SSA personnel are assigned to monitor Medicare operations at contractors' locations on a full-time basis. As a result, the resident representative is in a uniquely advantageous position to promptly identify deficiencies in the process and assure corrective action.

The Council expressed interest in comparing carrier and intermediary performance in claims processing, professional relations, and utilization control activities with similar performance indicators for Federal Employees Health Benefits Program carriers. This was not feasible because comparable tabulations and statistical information do not exist.

D. Incentive Experiments

Several incentive reimbursement experimentation proposals were reviewed pursuant to the Council's mandate to review such experiments with the Council approving some, while suggesting further development of others.

An example of an incentive reimbursement experiment which the Council approved is a Utah incentive reimbursement proposal to reimburse small, low occupancy rural hospitals in such a way as to encourage them to use their unneeded hospital beds as needed extended care beds and other long-term beds.

The Hospital Systems Institute (HSI), a subsidiary of General Instrument Corporation, proposed a 4-year program designed to test whether a reimbursement incentive can induce hospitals to utilize a combined program of industrial and systems engineering, behavorial and social sciences, health care administration, and business management to aid in controlling the rise in hospital costs. The Council recommended HSI and SSA staffs work together to further develop the experimental aspects of the proposal and it has been referred to the Office of the Secretary for a decision.

The Council was deeply concerned with the limited progress in the Incentive Reimbursement Experimentation Program and suggested a thorough review of the program including an in-depth comprehensive report to the Council on Federal and non-Federal sponsored incentive reimbursement experimentation generally.

In a report to the Council, the Social Security Administration pointed out that, while the 1967 amendments to the Social Se-

curity Act sought to tap the reservoir of ideas for reimbursement incentives believed existent in the health services industry, the great majority of the many proposals were unsuitable because they either did not meet the legislative requirement of increasing economy or efficiency, or did not provide any indication as to how the ideas should be developed. Other explanations for the modest pace of the experimentation program included a lack of anticipated research expertise in the health care field; a general misunderstanding of the nature of the program; inability to obtain voluntary participation of providers; and proposals received for hospital reimbursement experiments from individuals with no connection with such institutions and little hope of establishing associations, as well as proposals from single hospitals that would require participation of multiple units. Other proposals were not appropriate because (1) the prospective hospital participants could not accept the terms of a penalty provision in a plan, (2) they were not innovative, (3) they did not propose a change in reimbursement, or (4) proposed testing methods already documented as not working out well.

The Council also received a report from the Director of the Harvard University Center for Community Health and Medical Care on incentive reimbursement experiments being conducted under auspices other than Medicare. The director presented an overview of six Blue Cross plans, three medical foundations, and one group practice prepayment plan which had sponsored attempts by third-party payers to influence providers to act in ways the sponsors believed would promote more efficient uses of health dollars. He focused on one relatively narrow use of the mechanism of reimbursement as an instrument to stimulate change and cited pertinent experiences in requiring approval for new facilities and services, promoting mergers and shared services, developing new services, and assuring appropriate use of resources among delivery system components. Within institutions, he cited controlling overall cost increases, reducing lengths of stay, setting production norms, monitoring activities, establishing budget reviews, and setting prospective rates as examples of various incentive approaches to promote efficiency and reduce costs.

E. Eligibility for Renal Dialysis Benefits

A presentation by National Kidney Foundation representatives was given to the Council relating to Medicare coverage of hemodialysis and renal transplantation under P.L. 92–603. The Foundation emphasized that avoiding the cost of caring for the

complications resulting from untreated kidney disease would more than justify the lesser cost of effective treatment of the kidney disease itself. At its meeting in May 1973, the Council requested an opportunity to comment on an early draft of the guidelines for Medicare eligibility on the basis of chronic renal disease.

F. Professional Standards Review Organizations

The Professional Standards Review Organization concept, as embodied in H.R. 1 (P.L. 92–603), was of great interest to the Council. The importance of establishing cooperative working relations between the new PSRO's and the Medicare and Medicaid programs is obvious.

The Council reviewed the statutory provisions establishing PSRO's, considered problems that might arise in implementation, and will continue to keep closely abreast of developments pertaining to this review mechanism.

Appendix 1

Department of Health, Education, and Welfare

CHARTER

Health Insurance Benefits Advisory Council

Purpose

The Secretary is charged with statutory responsibility for administration of the health insurance for the aged (Medicare) and medical assistance (Medicaid) programs established by P.L. 89–97 (July 30, 1965), as amended, the implementation of which requires the advice of the Health Insurance Benefits Advisory Council.

Authority

42 U.S. Code 1395 dd (P.L. 89–97 as amended by P.L. 92–603). This Council is governed by the provisions of E.O. 11671, which sets forth standards for the formation and use of advisory committees.

Function

The Health Insurance Benefits Advisory Council provides advice and recommendations for the consideration of the Secretary on matters of general policy with respect to the health insurance for the aged and medical assistance programs set forth in titles XVIII and XIX, respectively, of the Social Security Act, as amended.

Structure

The Council consists of 19 members, not otherwise in the employ of the United States, who are selected by the Secretary from among persons outstanding in fields related to hospital, medical, and other health activities, persons who are representative of organizations and associations of professional personnel in the field of medicine, and at least one person who is representative of the general public. The Secretary shall, from time to time, appoint one of the members to serve as Chairman.

Each member shall hold office for a term of 4 years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and that terms exceeding the Council's termination date are contingent upon its renewal by appropriate action prior to expiration.

Management and staff services are provided by the Social Security Administration and Director, Advisory Groups Staff, Bureau of Health Insurance, who serves as Executive Secretary.

Meetings

Meetings are held at the call of the Secretary or his designee, but not less than annually, with appropriate advance notice to members. The agenda receives advance approval of a Government official. A Government official is present at all meetings.

Meetings are open to the public except as determined otherwise by the Secretary; notice of all meetings is given to the public.

Meetings are conducted and records of the proceedings kept, as required by applicable laws and departmental regulations.

Compensation

Members, who are not full-time Federal employees, are paid at the rate of $100 a day, including travel time, and receive per diem and travel expenses in accordance with Standard Government Travel Regulations.

Annual Cost Estimate

Estimated annual cost for operating the Council, including compensation and travel expenses for members, but excluding staff support is $75,000. Estimate of annual man-years of staff support requirement is 7.0 man-years, at an estimated cost of $118,000.

Reports

An annual report is submitted to the Secretary through the Commissioner, Social Security Administration, and the Commissioner, Medical Services Administration, Social and Rehabilitation Service, not later than December 31 of each year, and contains as a minimum a list of members and their business addresses, the dates and places of meetings, and a summary of the Council's activities and recommendations made during the year. A copy of the report is provided to the Department Committee Management Officer.

Termination Date

Unless renewed by appropriate action prior to its expiration, the Health Insurance Benefits Advisory Council will terminate on 1/4/75.

Approved:

January 4, 1973

Date	Secretary

Appendix 2

Health Insurance Benefits Advisory Council

November 30, 1972

Honorable Elliot L. Richardson
Secretary of Health, Education,
and Welfare
330 Independence Avenue, SW.
Washington, D.C. 20201

Dear Mr. Secretary:

As you will recall, the Health Insurance Benefits Advisory Council has in the past expressed to you our opposition to coverage of chiropractic services under the Medicare program. Now that a limited coverage of such services has been enacted into law, we believe it particularly important that chiropractic services be recognized only to the extent required by the law. To this end, we would like to offer our continuing advice and assistance in developing policies, to be reflected in regulations, which will provide maximum safeguards for the health and safety of both Medicare and Medicaid beneficiaries and protection against runaway costs to the Medicare and Medicaid programs.

The Council recommends, as a basis of approach, that the establishment of general policies provide that:

1. Only the specific treatment authorized by the law, i.e., manual manipulation of the spine, is reimbursed.

2. Only the services of qualified chiropractors are reimbursed.

3. That payment is made only for the treatment of the specific diagnosis covered in the law—subluxation of the spine demonstrated by X-ray.

We are confident that you share our concerns about this new coverage area and concur in our view that the regulations relating to chiropractic services should be carefully drawn to cover only those services intended by the Congress.

Sincerely yours,
James R. Cowan, M.D.
Chairman
Health Insurance Benefits
Advisory Council